Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
8108 FOX CREEK TRAIL
DALLAS TX 75249

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-0902-01

MFDR Date Received
NOVEMBER 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "."

Amount in Dispute: $2,212.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "All billing paid except 1-24-11 & this is being re-reviewed, provider notified."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2011 February 10, 2011 February 15, 2011 February 16, 2011	Chronic Pain Management – CPT code 97799-CP (4 hours)	$400.00/day X 4 = $1,600.00	$1,600.00
January 28, 2011	Chronic Pain Management – CPT code 97799-CP (4 hours)	$112.00	$112.00
February 17, 2011	Chronic Pain Management – CPT code 97799-CP (3 hours)	$300.00	$300.00
February 18, 2011	Chronic Pain Management – CPT code 97799-CP (2 hours)	$200.00	$200.00
TOTAL		$2,212.00	$2,212.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.

On January 16, 2013, the Division contacted Gallagher Bassett and requested payment summaries for the disputed services. At the time of this review, Gallagher Bassett did not contact the Division or submit the requested payment summaries.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
- BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.
- W1-Workers Compensation state fee schedule adjustment.
- 19-(198)-Precertification/authorization exceeded.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Does the submitted documentation support billed service?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (l) states "The carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:
   (1) the specific health care;
   (2) the approved number of health care treatments and specific period of time to complete the treatments; and
   (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury."

   28 Texas Administrative Code §134.600(p)(10) requires preauthorization for chronic pain management programs.

   On January 10, 2011, the requestor obtained preauthorization for ten pain management sessions for a total of 80 hours, beginning on January 5, 2011 ending on April 29, 2011.

   The respondent states in the position summary that "All billing paid except 1-24-11 & this is being re-reviewed, provider notified."

   The Division finds that the documentation does not support the denial of the dispute chronic pain management program based upon no preauthorization.

2. According to the explanation of benefits, the respondent denied reimbursement based upon reason code "16".
   A review of the submitted documentation supports the billed chronic pain management program; therefore, reimbursement is recommended.

3. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP for twenty five hours. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the twenty five hours billed is $2,500.00. The respondent paid $288.00. The difference between the MAR and amount paid is $2,212.00. This amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $2,212.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,212.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		2/14/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.